

PRINTED: 02/06/2018
FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 CLIVE DRIVE SW CEDAR RAPIDS, IA 52404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 557	<p>Continued From page 1</p> <p>and participate in care as able and provide assistance with dressing, bathing, toileting and hygiene.</p> <p>During observation on 1/22/18 at 2:26 p.m., the resident requested to use the toilet. Staff A, Certified Nurse Aide, CNA told the resident at this point the resident would have to be assisted by second shift. Staff A continued to tell the resident due to the residents transfer status, to just go in their brief and the 2-10 shift would come in and clean the resident up. The CNA emptied the residents catheter and left the room.</p> <p>During interview on 1/22/18 at 2:28 p.m., the resident stated this place makes me so mad.</p> <p>During interview on 1/29/18 10:16 a.m., Staff B, CNA stated if the resident needed to toilet, they would give the resident the bedpan. Staff B stated residents that use a Hoyer lift to transfer get to use the bedpan or check and change. Staff B continued to report they would not tell a resident to go to the bathroom in the bed and wait for next shift to clean them up.</p> <p>During interview on 1/29/18 10:35 a.m., Staff C, CNA reported each resident task directs the care. Staff C reported it would never be ok to tell a resident to go in the bed and get cleaned up later. Have to take care of them at that point they ask for help.</p> <p>During interview on 1/29/18 at 01:06 p.m., Staff F, Registered Nurse, RN reported staff need to take the resident to the toilet if asked or give them the bedpan. The aides carry I-Pads that tell them how residents toilet. Staff F concluded it would not be ok to tell a resident to go to the bathroom in bed</p>	F 557			

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F 557	Continued From page 2 and get cleaned up later. During interview on 1/29/18 01:37 p.m., the director of nursing, DON stated the expectation was if a resident asked to use the toilet staff are expected to take the resident to the toilet. A resident who transfers with a Hoyer lift can be transferred on to the toilet, commode or use a bedpan, what ever the resident wishes. Staff should never tell a resident to be incontinent and staff will clean them up later.	F 557		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to conduct Quality Assessment and Assurance (QAA) meetings on a quarterly basis. The facility census was 116 residents.	F 868		

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F 868	Continued From page 3 Findings include: 1. During interview on 1/29/18 at 10:00 a.m., the Administrator shared QAA sign in documentation of meetings with the required committee members, which included 3/1, 3/30, 10/19 and 12/21/17 and confirmed the facility did not hold a QAA meeting, with the required committee members, between 3/30 and 10/19/17. The Administrator reported a QAA meeting was scheduled for July, but canceled due to an issue with a ceiling collapse in Station 3B. He reported an adhoc QAA meeting occurred in July but did not include the medical director and only addressed the ceiling collapse. A facility policy titled "Quality Assurance Reports" identified a guideline which specified the Administrator and/or the Director of Nursing scheduled routine quarterly meetings.	F 868			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880			

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F 880	<p>Continued From page 4</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents</p>	F 880			

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F 880	<p>Continued From page 5</p> <p>identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure staff utilized proper infection control techniques when providing catheter care for one of four residents with a catheter. (Resident #108) The facility census was 116 residents.</p> <p>Findings Include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 12/30/17, documented Resident #108 had diagnoses that included obstructive uropathy of the bladder, diabetes mellitus and peripheral vascular disease and required extensive assistance with most activities of daily living (ADL).</p> <p>The Care Plan dated 1/23/18, documented the resident had a urinary catheter and nursing staff was directed to provide catheter care every shift, encourage fluids and change the catheter per orders.</p>	F 880			

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F 880	<p>Continued From page 6</p> <p>During observation on 1/24/18 at 11:10 a.m., Staff D, Certified Nurse Aide, CNA washed their hands and gloved. Staff D retrieved a graduated cylinder off the top of the toilet that was upside down on a paper towel on top of a plastic bag. Staff D placed a clean plastic bag on the floor near the bed under the catheter bag, placed paper towels in the plastic bag and the graduated cylinder on the paper towels. Staff D lifted the cover to the catheter bag, took the end of the tubing out of the holder and before opening the bag wiped off the end of the tubing with a wet wipe used in providing peri-cares for residents, not an alcohol pad. When done emptying out the urine from the catheter bag Staff D wiped off the end of the tubing using the same wet wipe and clamped it shut and placed the tubing back in the holder on the outside of the catheter bag. At no time while the catheter was emptied was an alcohol pad utilized to cleanse the end of the catheter tubing.</p> <p>Review of the Curity wet wipe container used to clean off the end of the resident's catheter documented the wet wipe to be a pre-moistened wash cloths, Hypoallergenic formula was safe for sensitive skin. For use on face, hands and body. The package of wipes identified the wipes to be Alcohol Free and with Vitamin E, Chamomile and Aloe Vera ingredients.</p> <p>During interview on 1/29/18 at 1:48 p.m., Staff G, CNA state they would use an alcohol pad to cleanse the end of the bag off after the urine was emptied out and before closing the bag and putting the spout bag in the receptacle on the side of the catheter bag.</p> <p>During interview on 1/29/18 at 2:21 p.m., Staff E, Assistant Director of Nursing</p>	F 880			

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F 880	<p>Continued From page 7</p> <p>stated when the aide opens the end of the catheter bag to empty the urine, they should cleanse the end of the bag with an alcohol wipe, empty out the urine into the graduate and measure the urine amount. Before clamping the catheter bag shut they should cleanse the spout again with another alcohol wipe.</p> <p>Review of the Catheter- Emptying of Policy from the Nursing Guidelines and Procedure Manual dated January 2015 edition explained the procedure. The equipment to gather to be gloves, alcohol swabs, a graduate cylinder and paper towels. Assemble equipment, wash hands, put in gloves, put a plastic bag under the graduate, and remove the catheter bag from the protective covering if applicable. Open drain and let urine run into graduate, avoid contaminating the drain, allow urine in tubing to drain into the collection bag. Clamp tubing; wipe drain with alcohol swab and place drain bag in protective covering if applicable.</p>	F 880			

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE SPECIALTY CARE

200 CLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

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L1093	<p>58.12(1) Admission, transfer, and discharge</p> <p>58.12(135C) Admission, transfer, and discharge.</p> <p>58.12(1) General admission policies.</p> <p>I. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party.</p> <p>For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004.</p> <p>If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical</p>	L1093		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

STATE FORM

5500

LF8P11

If continuation sheet 1 of 3

DEPARTMENT OF INSPECTIONS AND APPEALS

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L1093	<p>Continued From page 1</p> <p>assistance program established under Iowa Code chapter 249A.</p> <p>The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III)</p> <p>This Statute is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to report resident admissions to the Iowa Department of Veterans Affairs (VA) for two of 20 residents reviewed for VA eligibility (Resident #73 & #374) The facility census was 116 residents.</p> <p>Findings include:</p> <p>1. Review of the facility Iowa Department of Veterans Affairs Resident Eligibility list dated 1/23/18, revealed Resident #73 and #374 did not appear on the list.</p> <p>Review of a facility document titled "Veterans VA Check", dated 11/13/17, identified Resident #73 as a veteran and census information identified he remained a resident in the facility.</p> <p>Review of a facility document titled "Veterans VA Check", dated 8/31/17, identified Resident #374 as a veteran. A facility discharge report, dated 1/15/18, revealed he discharged 12/20/17.</p> <p>During interview on 1/29/18, at 1:10 p.m., the Administrator reported the Admissions Coordinator or the Social Worker assisted in gathering veteran information on admission. The Administrator confirmed the two residents should have been added to the Iowa Department of</p>	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

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L1093	Continued From page 2 Veterans Affairs Resident Eligibility data base and were missed.	L1093		

Plan of correction for Prefix Tag F557

Please accept this as the credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. Professional standards of quality will be provided by:

Resident # 93 was appropriately assisted to toilet by oncoming staff. Staff A was educated on timeliness of providing requested assistance and the importance of treating residents with respect and dignity, prior to his next scheduled shift. Facility guidelines were reviewed with consideration to an identified lapse of providing resident care in a dignified manner, the process was followed and employment of staff A ended on 1-31-18. Re-education will be completed with nursing staff by 2-27-18 including the importance of providing care to all residents in a dignified manner and appropriate options for toileting residents. The DON/ADON/Designee will complete four resident interviews weekly for four weeks then monthly for two months to identify that staff treat residents with dignity and respect. All identified concerns will be addressed immediately. A summary of findings will be presented at monthly QA meeting for review and further recommendations. Compliance March 2, 2018.

Plan of correction for Prefix Tag F868

Please accept this as the credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. Professional standards of quality will be provided by:

Administrator will receive information about CMS's federal tag 868 regarding the frequency and members required for the Quality Assessment and Assurance Committee. Administrator will conduct Quarterly QA&A meetings with the required membership. Care Initiatives designee will monitor quarterly for compliance and report any issues to the QA&A committee members. Compliance March 2, 2018.

Plan of correction for Prefix Tag F880

Please accept this as the credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. Professional standards of quality will be provided by:

Resident # 108 had his catheter bag changed on 1-30-18. Staff D was re-educated on 1-30-18 regarding the importance of infection control and a skills checklist was completed to ensure correct infection control technique was maintained when emptying a catheter bag. Catheter bags were changed for all residents with catheters on 1-30-18. A skills checklist will be completed with nursing staff by 2-27-18 to ensure correct infection control technique was maintained when emptying a catheter bag. The DON/ADON/Designee will complete five random infection control audits weekly for four weeks then monthly for two months to validate infection control technique is maintained when emptying a catheter bag. All identified concerns will be addressed immediately. A summary of findings will be presented at monthly QA meeting for review and further recommendations.

Administrator will receive information about CMS's federal tag 868 regarding the frequency and members required for the Quality Assessment and Assurance Committee. Administrator will conduct Quarterly QA&A meetings with the required membership. Care Initiatives designee will monitor quarterly for compliance and report any issues to the QA&A committee members. Compliance March 2, 2018.

Plan of correction for Prefix Tag L1093

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Administrator will provide education to the Admissions Coordinator and/or designee by February 13, 2018 on ensuring Veteran Benefits are checked during admissions when residents are identified as having potential Veteran Benefits. Administrator or designee will monitor admissions for 3 weeks to ensure compliance and review quarterly through audits and report any issues to the Quality Assessment and Assurance Committee. March 2, 2018